NURSE AIDE TRAINING PROGRAM PRIMARY INSTRUCTOR APPLICATION

The US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) authorizes the Department of Health and Family Services to review and determine eligibility for nurse aide primary instructors under the requirements of the Medicare and Medicaid programs. Completion of this form is voluntary; however, the information collected on this form is used determine if federal and state primary instructor eligibility requirements have been met. Providing the primary instructor's social security number is voluntary; however, social security numbers are one of the unique identifiers used to prevent incorrect identity mismatches, e.g., the Department of Justice uses social security numbers, names, gender, race and date of birth to prevent incorrect matches of persons with criminal convictions.

COMPLETE, SIGN AND MAIL THIS FORM TO:
Wisconsin Nurse Aide Training Consultant
Bureau of Quality Assurance
Office of Caregiver Quality
2917 International Lane, Suite 300
Madison, WI 53704

PRINT NEATLY IN BLACK INK OR TYPE THE FOLLOWING INFORMATION

I. PERSONAL INFORMATION

- Provide a copy of your Social Security card and a form of identification to verify your current name.
- Provide a copy of your current Wisconsin nursing license
- Provide a copy of completed BID, DOJ and DHFS Responses.

NOTE: To be approved as a primary instructor, state and federal regulations require that you are a registered nurse, currently licensed to practice in Wisconsin

Full Name (Last, First, Middle Initial) **DO NOT USE NICKNAMES**		WI Nursing License Number
Social Security Number	Birth Date (mm/dd/yyyy)	Gender ☐ Female ☐ Male
Current Mailing Address (Street / P.O. Box Number)		
City	State	Zip Code
Home Telephone Number	Work Telephone Number	
E-mail address		
Name – Training Program You Intend to Instruct		

II. EDUCATION

Provide a copy of your Train the Trainer certificate.

School / College	Year of Graduation
School / College	Year of Graduation
School / College	Year of Graduation
Train the Trainer Course	Date of Graduation
Substantially Equivalent Training Course Description	Date of Training Graduation

III. HEALTH CARE EMPLOYMENT INFORMATION

- List the names and locations of all health care facilities at which you have been employed as a registered nurse, as well as the dates of employment. Check the appropriate box to indicate the type of health care facility.
- Attach a copy of your resume to verify your education, work history and clinical experience in meeting clients' psychosocial, behavioral, cognitive and physical needs.

NOTE: For primary instructor approval, state and federal regulations require you have a minimum of two years of experience working as a registered nurse, of which at least one year must be in the provision of long term care.

Name / Location – Health Care Facility	Employment Dates	Facility Type
	From to	☐ Nursing Home ☐ ICF/MR ☐ Home Health Agency ☐ Hospice ☐ Hospital ☐ Other
Name / Location – Health Care Facility	Employment Dates	Facility Type
	From to	☐ Nursing Home ☐ ICF/MR ☐ Home Health Agency ☐ Hospice ☐ Hospital ☐ Other
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Name / Location – Health Care Facility	Employment Dates	Facility Type
	From to	☐ Nursing Home ☐ ICF/MR ☐ Home Health Agency ☐ Hospice ☐ Hospital ☐ Other

1. List specific job duties (attach separate page as needed)

2. List and describe employment in the care of the chronically ill.

3. List and describe home health care experiences (if applicable).

DHFS USE ONLY

☐ Primary Instructor Approved
☐ Approval Pending, Information Needed
☐ Primary Instructor Denied
Reason for Denial: _____

_____

Name – Reviewer	Title	Date Reviewed